

**AGING AND ADULT SERVICES  
AND  
MEDICAL ASSISTANCE ADMINISTRATION**



**NURSING FACILITIES**

**Billing Instructions**

**August 1997**



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## **PREFACE**

***This publication supersedes all previous  
Nursing Facilities billing instructions***

Send TAD for nursing home services for Washington State Medical Assistance clients to the Medical Assistance Administration within the Department of Social and Health Services at the following address:

**DIVISION OF PROGRAM SUPPORT  
617 8TH AVENUE  
PO BOX 9250  
OLYMPIA WA 98507-9250**

If you have questions regarding *policy*, *payments*, *denials*, or *general questions* regarding claims processing call:

**PROVIDER INQUIRY & RELATIONS  
1-800-562-6188**

For questions regarding *private insurance* and *third-party liability* call:

**COORDINATION OF BENEFITS  
1-800-562-6136**

For what is included in the nursing home per diem or for rate questions please call:

**AGING AND ADULT SERVICES  
1-800-422-3263**

## **DEFINITION GUIDE**

The "Definition Guide" contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Medical Assistance program.

**ACCEPT ASSIGNMENT** - A process through which a medical provider agrees to accept the Medicare program's payment as payment in full, except for specific coinsurance and deductible amounts required of the client.

### **AGING AND ADULT SERVICES**

**ADMINISTRATION (AASA)** - As a component of the Washington State Department of Social and Health Services, AASA provides a broad range of social and health services to adult and older persons living in the community and in residential care settings. These services are designed to establish and maintain a comprehensive and coordinated service delivery system which enables persons served to achieve the maximum degree of independence and dignity of which they are capable.

**CLIENT** - An applicant for or recipient of DSHS medical care programs. (WAC 388-500-0005)

**CODE OF FEDERAL REGULATIONS (CFR)** - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**COMMUNITY SERVICES OFFICE (CSO)** - An office of the department which administers social and health services at the community level. (WAC 388-500-0005)

**CORE PROVIDER AGREEMENT** - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program. [See WAC 388-87-007]

**DEPARTMENT (DSHS)** - The state department of social and health services. (WAC 388-500-0005)

### **DIVISION OF DEVELOPMENTAL**

**DISABILITIES (DDD)** - The division in DSHS responsible for administering and overseeing services for clients with developmental disabilities.

**EXPLANATION OF BENEFITS (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**FRAUD** - No person, firm, corporation, partnership, association, agency, institution, or other legal entity, but not including an individual public assistance recipient of health care, shall, on behalf of himself or others, obtain or attempt to obtain benefits or payments under this chapter in a greater amount than that to which entitled by means of:

- (a) A willful false statement
  - (b) By willful misrepresentation, or by concealment of any material facts; or
  - (c) By other fraudulent scheme or device, including, but not limited to:
    - (i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or
    - (ii) Repeated billing for purportedly covered items, which were not in fact covered.
- (RCW 74.09.210)

**HOME AND COMMUNITY SERVICES** - This division promotes, plans, develops and provides long-term care services responsive to the needs of persons with disabilities and the elderly with priority attention to low-income individuals and families. They assist people with disabilities and their families obtain appropriate quality services to maximize independence, dignity, and quality of life.

**INSTITUTIONAL AWARD LETTER** - An official document issued by the local DSHS Community Services Office (CSO) which provides information about a nursing facility resident. The information pertains to the MAA client's income and resources, their medical care eligibility, the effective date for care, the care level, Medicare status, etc.

**INTERMEDIATE/MENTAL RETARDATION FACILITY (IMR)** - A facility in which nursing supervision of health care, habilitation, and active treatment services are provided for mentally retarded residents or those with related conditions.

**MEDICAID** - The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in WAC 388-503-0310 and 388-503-1105; or
- Medically needy as defined in WAC 388-503-0320. (WAC 388-500-0005)

### **MEDICAL ASSISTANCE ADMINISTRATION**

**(MAA)** - The administration within the department of social and health services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

**MEDICALLY NECESSARY** - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

**MEDICARE** - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

**NURSING FACILITY (NF)** - A home, place, or institution, licensed under chapter 18.51 or 70.41, RCW, where skilled nursing care services are delivered. (WAC 388-96-010)

### **NURSING FACILITY RATES FOR AASA**

**PAYMENT** - Prospective reimbursement rates as outlined in WAC 388-96-704.

**PATIENT IDENTIFICATION CODE (PIC)** - An alphanumeric code which is assigned to each Medicaid client and which consists of:

- a) First and middle initials (or a dash [-] must be entered if the middle initial is not indicated).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name (and spaces if the name is fewer than five letters).
- d) Alpha or numeric character (tie breaker).

**PAYOUT** - A payment MAA makes to a nursing facility based on the facility's turnaround document (TAD).

**PER DIEM COSTS** - (Per patient day or per resident day) Total allowable costs for a fiscal period divided by total patient or resident days for the same period. (WAC 388-96-010)

**PROVIDER or PROVIDER OF SERVICE** - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department. (WAC 388-500-0005)

### **PROGRAM SUPPORT, DIVISION OF (DPS)**

The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

### **RATE ADJUSTMENTS FOR DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)**

Submitted to the division's assigned analyst. See WAC 275-38-906.

### **REMITTANCE AND STATUS REPORT (RA)**

A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

**RESIDENT** - A person residing in a nursing home. The term resident excludes outpatients and persons receiving adult day or night care, or respite care.

**REVISED CODE OF WASHINGTON (RCW)** - Washington State laws.

**THIRD PARTY** - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. (WAC 388-500-0005)

**TITLE XIX** - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

**TURNAROUND DOCUMENT (TAD)** - A list, on a MAA form, of MAA clients that currently reside in a nursing or DDD facility. This form is mailed to the facility for the purpose of billing the state.

**WASHINGTON ADMINISTRATIVE CODE (WAC)** - Codified rules of the state of Washington.

## MEDICAL ASSISTANCE ADMINISTRATION (MAA) GENERAL INFORMATION AND POLICY

- I. BILLING TIME LIMIT: State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service (RCW 74.09.160)
- II. PAYMENT: MAA may be billed only after you provide a service to an eligible client. Delivery of a service or product does not guarantee payment. For example, MAA will not make payment when:
- The request for payment is not presented within the 365-day billing limit;
  - The service or product is not medically necessary or is not covered by MAA;
- OR
- The client has third-party coverage and the third party pays as much as, or more than, MAA allows for the service or product.

If you provide services to a person who is not eligible for a medical program and who is later determined to be eligible, you may be paid by MAA when:

- The service is determined to be medically necessary, it is within MAA's scope of care, and it is a service covered by MAA policy; AND
  - The client provides you with a medical ID card which covers the date of service and that covered service is billed within 365 days of the date it was provided;
- OR
- Your claim is presented within 365 days from the retroactive or delayed certification date indicated on the MAA medical ID card.

When the retroactive certification legend appears on a medical ID card, it indicates that the applicant received a service and applied in a later month for a medical program. Upon approval of the application, the person was found to be eligible for the medical program at the time he or she received the service.

The delayed certification legend appears on the medical ID card when a person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service.

(Refer to the MAA General Information Booklet for more specific information on medical ID card legends.)

- III. **THIRD-PARTY LIABILITY:** You must notify MAA if you know of any third-party liability insurance and the corresponding insurance code is not listed on the medical ID card.

Notify MAA through one of the following methods:

1. Call: 1-800-562-6136
2. Write to MAA: **DIVISION OF CLIENT SUPPORT  
COORDINATION OF BENEFITS PROGRAM  
PO BOX 45565  
OLYMPIA WA 98504-5565**
3. Write "Insurance" and the name of the insurance company in the Comments section of the Turnaround Document (TAD).

If you receive payment from a third-party insurance source after MAA has made payment, you can either refund MAA by check or you can submit an adjustment.

Whichever payment amount is less should be refunded to MAA. Attach any identifying information from the payer to the refund check, along with a copy of the MAA Remittance and Status Report showing the original payment.

Send to:

**OFFICE OF FINANCIAL RECOVERY - MED  
PO BOX 5862  
OLYMPIA WA 98504-5862**

If you prefer, you may submit an adjustment using the blue Adjustment Request form 525-109. Attach any identifying information from the payer and a copy of the MAA Remittance and Status Report showing the original payment to the adjustment request.

If you have any questions regarding third-party liability, call the Coordination of Benefits Program at 1-800-562-6136.

IV. CHARTS/RECORDS: You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. Chart means a summary of medical records on an individual patient. Record means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be entered in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and shall include, but not be limited to:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Records must be available to DSHS and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs.

V. ADVANCE DIRECTIVES: All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give all adult clients written information about their rights, under state law, to make their own health care decisions. The client's rights include: the right to accept or refuse medical treatment, the right to make decisions concerning his/her own medical care, and the right to formulate an advance directive, such as a living will or durable power of attorney, for his/her health care.

## **NURSING FACILITIES**

### **GENERAL INFORMATION**

#### **I. OVERVIEW**

The nursing facility billing process for Washington Medical Assistance clients has been developed in cooperation with the nursing facility industry, the Division of Developmental Disabilities (DDD), the Aging and Adult Services Administration (AASA), the State Legislature, and the Medical Assistance Administration (MAA).

Nursing facility services provided to MAA clients are funded through the DSHS, AASA and claims processed through the Medical Assistance Administration's claims processing system. Refer to Chapter 74.46 RCW (Nursing Facility Auditing and Cost Reimbursement Act of 1980) for further information.

Nursing facility services for DDD clients are covered under RCW 71A and WAC 275-38.

A nursing facility is defined as a home, place, or institution licensed under chapter 18.51 or 70.41 RCW, where nursing care services are delivered. (WAC 388-96-010)

An IMR facility for DDD is defined as a Title XIX-certified intermediate care facility for the mentally retarded in which services are provided to mentally retarded persons or persons with related conditions. These facilities:

- Provide IMR services to eligible clients who require intensive habilitation training;
- Provide support services which may best be provided in a 24-hour residential care facility; and
- Meet the standards and guidelines of the federal nursing facility IMR program.

#### **II. CLIENT ELIGIBILITY**

MAA clients eligible for nursing facility services will have an award letter and a medical ID card that is valid on the date(s) which services are provided. See the MAA General Information Booklet for more information on medical ID cards.

Hospice Clients Who Are Nursing Facility Residents: Eligible clients who reside in a nursing facility may elect to receive hospice services excluding nursing home inpatient respite care. Further information may be obtained by consulting the MAA Hospice Billing Instructions.

Healthy Options: Nursing facility or home and community based services covered by the Aging and Adult Services Administration are not covered under the Healthy Options contract. This includes all services paid under the nursing facility's per diem.

SSI clients residing in a nursing facility may be eligible for Healthy Options coverage for services provided outside of the per diem.

### III. PAYMENT PROCESS

Nursing facilities typically receive payment for services rendered in a particular month at the beginning of the following month. For example, the payment for August services is processed by MAA during the latter half of August. Providers receive payment at the beginning of September (see the following diagram). This initial payment, or payout made by MAA to the facility, is 90% of what MAA estimates will be owed for June based on information from the facility's Turnaround Document (TAD) from the previous month (May).

Step 1: MAA generates a TAD.

Step 2: MAA pays the facility 90% of the amount MAA estimates it will owe the facility, based on information from the last TAD submitted by the facility.

Step 3: MAA sends the TAD to the nursing facility after the 90% payouts are calculated. TADs are mailed slightly before the 90% payouts are mailed. The nursing facility modifies the TAD based on:

- the current month's medicaid patient census, and
- the status of each patient who is an MAA client (discharged, deceased, still a patient, etc.).

Step 4: The nursing facility returns the TAD with the appropriate changes within the first two weeks of the month.

Step 5: MAA uses the TAD from the nursing facility to reconcile the account/credit balance for that facility.

Step 6: Once the nursing facility TAD and MAA's 90% payout for the month are reconciled, MAA will send a warrant to the facility for the total amount of the claims, minus the 90% prepayment.

#### IV. CALCULATING THE 90% PAYOUT

The following is an example of a payout calculation for the month of June.

##### **AUGUST**

(Last weeks of month)

90% payout is calculated for August based on the facility's rate, the number of patients in the facility in May, their patient pay, their class, and the number of days in August. The August TAD is mailed to the provider. The 90% payout (warrant) is mailed to the provider.

##### **SEPTEMBER**

(First weeks of month)

The provider updates the August TAD. After the TAD is returned, MAA processes the August TAD using the data supplied by the facility along with rate changes (if any) processed by AASA/DDD that month. The August TAD is reconciled with the 90% payout. A warrant for the difference, if any, is mailed to the provider.

2

Additional Information:

##### Patient Class Codes

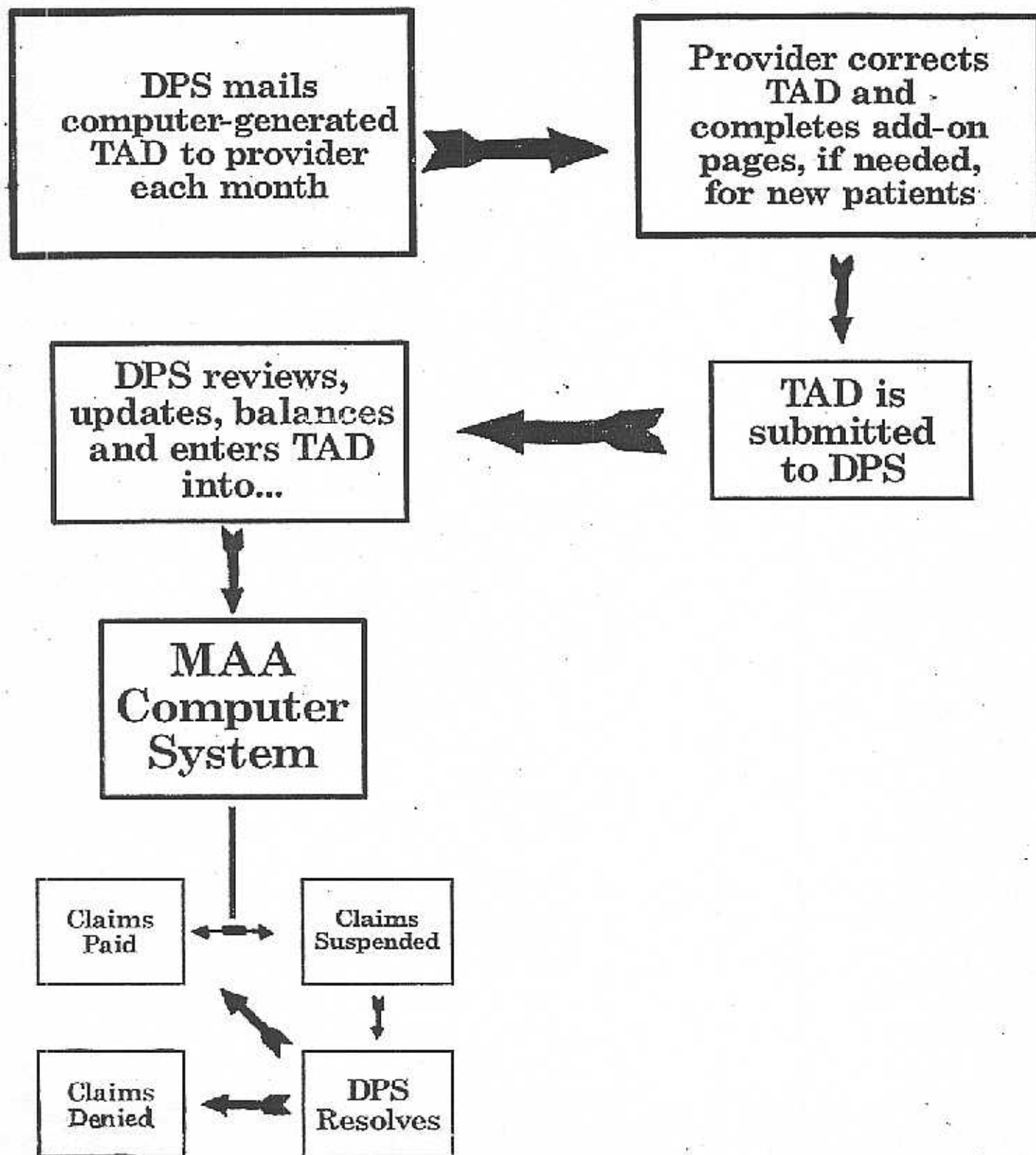
- 20 - Skilled Nursing Facility Patient/Resident Routine Care (Medicaid)
- 23 - Intermediate/Mental Retardation Services - Title XIX Eligible
- 24 - Dual Medicare/Medicaid
- 25 - Exceptional Care: Additional Care Required Exceeding Ordinary/Routine Care (Medicaid)
- 26 - Swing Bed is a Hospital Bed Primarily Acute Care, but designated for use as a Long Term Medicaid Overflow Bed.
- 27 - Intermediate/Mental Retardation Services - Not Title XIX Eligible
- 29 - Nursing Facility Resident Paid in Full by Medicare

These patients/residents codes determine the amount of payment to the nursing facility for the patient/resident care and draw against the proper funding source based upon eligibility.

##### Patient Pay

The amount representing the patient/resident's responsibility determined while establishing eligibility for Medicaid paid nursing care. This is specific to the patient/resident's and this amount can change in cases where the individual patient/resident's financial resources change. Eligibility is established by a Financial Worker at the local Community Services Office in the patient/resident's area.

# TAD FLOW CHART



## **CORRECTING A TURNAROUND DOCUMENT (TAD)**

**See example of a blank TAD on the next page.**

1. Verify *each line* on the preprinted TAD for accuracy.
2. When changes need to be made to preprinted information, write the revision *above or below* the existing information and *draw a single line through the preprinted information*. (See "Filling Out Corrections on the TAD" section)

***IMPORTANT: DO NOT BLOT OUT OR ERASE THE PREPRINTED INFORMATION. IT MUST REMAIN LEGIBLE!***

3. Print corrections and additions legibly in blue or black ink. Do not use red ink or highlighters.
4. If a patient has been dropped from the TAD without an apparent reason, enter the patient's name on an add-on line and write "dropped from TAD" in the *Comments* section. (See *Attachment J* for explanations and examples of add-ons.)
5. Alphabetize all add-ons as shown on *Attachment J*.
6. When a new MAA client has been admitted to your facility, attach the original institutional award letter for each new patient.
7. Before mailing the TAD, check to make sure you have enclosed all required documentation, such as institutional award letters and/or add-ons.
8. Mail the TAD by itself. Do not include the (DPS) TAD in the same envelope with any other claims.

***The TAD must be received by the Division of Program Support by the deadline listed on the cover letter sent with each month's TAD. If it is not received in our office by that deadline, your next 90% advance payment will be withheld until the previous TAD and necessary adjustments are received and reviewed by MAA.***

**Mail the TAD To:                   DIVISION OF PROGRAM SUPPORT  
  617 8TH AVENUE SE, BLDG. 1  
  PO BOX 9250  
  OLYMPIA WA 98507-9250**

For information concerning payments, adjustments, or any problems you may have concerning your TAD call:

**MAA PROVIDER INQUIRY & RELATIONS  
1-800-562-6188**

## NURSING HOME STATEMENT

MAIL TO: OFFICE OF PROVIDER SERVICES

P.O. BOX 9257

OLYMPIA, WA. 98507-9250

[illegible]

I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the same; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or physical handicap; that the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

525-010-1010/82

QUALITY COPY

PROVIDER SIGNATURE

DATE \_\_\_\_\_

FACILITY COPY

TELEPHONE NO. ( ) \_\_\_\_\_

## KEY TO BLANK TAD FORM

### TAD

**Header** - include nursing facility name, address, and provider number

- Box 1**        First and middle initial
- Box 2**        Month, day, year of birth
- Box 3**        Patient last name, first name, middle initial
- Box 4**        Tiebreaker
- Box 5**        Patient class code
- Box 6**        Discharge code
- Box 7**        Month services are rendered  
                   Year services are rendered  
                   Beginning date of service  
                   Ending date of service
- Box 8**        Total days billed
- Box 9**        Patient pay
- Box 10**       Rate for exceptional care only (Class 25)
- Box 11**       Comments

**3        Bottom right corner:** Provider signature, date, and telephone number.

The TAD will be discussed on the following pages starting with Box 5.

Examples showing how these boxes are completed can be found at the end of these  
 billing instructions.

## **FILLING OUT CORRECTIONS ON THE TAD**

During the payment process, a Turnaround Document (TAD) is created. MAA sends the TAD to the nursing facility after the 90% payouts are calculated. The TAD is modified based on:

- the number of days in the month
- the current month's medicaid patient census, and
- the status of each patient who is an MAA client (discharged, deceased, still a patient, etc.).

The nursing facility returns the TAD with the appropriate changes during the first two weeks of the month.

The following information outlines and explains the different portions of the TAD. Examples showing how to correct the preprinted information on the TAD are included in this section.

### **PATIENT CLASS CHANGES (Box 5)**

No award letter is needed to change the patient class. However, if the patient is coded as *Exceptional Care* (class 25), include a copy of your letter from the DSHS Aging and Adult Services Administration which shows the patient's name, the rate for his/her class, and effective dates of the exceptional care rate. (See *Attachments A and H*.)

#### **PATIENT CLASS CODES:**

##### Aging and Adult Services

- 20 - Skilled Nursing (Facility) (SNF)
- 24 - Dual Medicare/Medicaid
- 25 - Exceptional Care
- 26 - Swing Bed
- 29 - Paid in Full by Medicare

##### Developmental Disabilities

- 23 - Intermediate/Mental Retardation Services — Title XIX Eligible
- 27 - Intermediate/Mental Retardation Services — Noneligible for Title XIX

**Full Medicare**

Report the days Medicare paid in full (while the patient was in your facility and eligible for Medicaid) as class 29. You will not be paid for class 29 days, nor will you see them reported on your MAA Remittance Advice. Medicare/Medicaid coinsurance days should be reported with class 24.

Class 24-Medicare interim rate changes must be reported to DSHS via letter to the Nursing Home Supervisor or in comments field on TAD. Be sure to give the rate and effective date.

For full Medicare days, enter class 29 in box 5, the appropriate discharge code in box 6, the from and to dates in box 7, and the total days in box 8. (See *Attachment I*.)

**Class 24 (Dual Medicaid - Medicare) Payments**

Class 24, dual Medicaid-Medicare payments, are paid by Medicaid on a per diem basis only when Medicare pays less than the Medicaid allowed amount. The rate of payment per day is calculated as follows:

1. Take Medicare's full rate for that specific facility for the dates of service.

**Example 1: Per day, Medicare's full rate is 151.00 in '94**

**Example 2: Per day, Medicare's full rate is 418.00 in '94**

2. Reduce that by the standard Medicare skilled nursing coinsurance amount for the state of Washington for that year; this is the amount of 'Net Medicare' per day. The standard coinsurance amount is set by Medicare for each year, and is as follows:

1990 - 74.00	1993 - 84.50	1996 - 92.00
1991 - 78.50	1994 - 87.00	1997 - 95.00
1992 - 81.50	1995 - 89.50	

**Example 1: Per day '94 coinsurance is 87.00, subtracted from Medicare's full rate of 151.00 per day is 'Net Medicare' of 64.00 per day**

**Example 2: Per day '94 coinsurance is 87.00, subtracted from Medicare's full rate of 418.00 per day is 'Net Medicare' of 331.00 per day**

3. The 'Net Medicare' per day is then subtracted from the Medicaid facility rate for the dates of service. If the resulting number is negative, no amount is due the facility: Medicare has already paid more than the Medicaid allowed amount.

**Example 1:** 'Net Medicare' per day is 64.00, subtracted from Medicaid allowed of 114.00 per day is Medicaid payment of 50.00 per day

**Example 2:** 'Net Medicare' per day is 331.00, subtracted from Medicaid allowed of 114.00 per day is Medicaid payment of -217.00 per day: since negative Medicaid amounts are not allowed, no Medicaid payment is due

4. If the resulting number is positive, then we allow the difference. Multiply that difference by the number of days billed, then subtract patient participation, if any, to arrive at a final net Medicaid payment. If subtracting the patient pay causes the 'final net Medicaid payment' to be negative, the claim is 'paid' at 0.00.

**Example 1A:** Medicaid payment of 50.00 per day multiplied by 30 days is 1,500.00, less patient pay of 500.00 is final Medicaid payment of \$1,000.00

**Example 1B:** Medicaid payment of 50.00 per day multiplied by 30 days is 1,500.00, less patient pay of 1,700, resulting in final net Medicaid 'payment' of \$0.00 (the negative amount of -200.00 cannot be 'paid')

**Example 2:** No Medicaid payment is due

Each facility is responsible for notifying us, on their TAD billing and adjustment forms, of changes to their full Medicare rates, including the specific rate amount and the dates of service it applies to. As copies of Medicare's rate notices may be required by us, facilities can include copies of those with their TAD and adjustment billings for Class 24.

**DISCHARGE CODES (Box 6)**

If a patient is discharged from the nursing facility, use the following **DISCHARGE CODES**:

- 0 = Admit and discharge in same day
- 1 = To the hospital
- 2 = To another nursing facility
- 4 = Deceased
- 5 = To private pay, hospice agency, home, or on social leave
- 6 = Still a patient
- 7 = To a state hospital
- 9 = To a congregate care facility

**NOTE:** If the patient has not been discharged, use **code 6 - Still a patient**.

**Admit and Discharge in Same Day**

If a patient is newly admitted and discharged in the same day, discharge code 0 (zero) should be used. This **does not include**: (1) discharged, admitted, and discharged in the same day; (2) admitted, discharged, and admitted again in the same day; or (3) social leave.

For appropriate admit and discharge in the same day, enter discharge code 0 (zero) in box 6, the date in box 7, and 1 day in box 8. (See *Attachment D*.)

**Discharge to Hospital**

Enter the discharge code in box 6, the date of discharge in box 7, and total days in box 8.

*Note: The nursing facility is not paid for the date of discharge (keep in mind when totaling box 8). (See Attachment C.)*

**Social Leave**

The first 18 days of social leave in a year are paid by Medicaid. The patient should be reported as *still a patient* for these days. Do not discharge and readmit him/her. After 18 days of social leave have been used, report discharge and readmit only if the patient left the facility for at least a full 24-hour period.

**Discharge and Readmit During the Same Month**

**If a patient is discharged and readmitted within the same month, enter billing information directly above or below the preprinted line of the TAD or as an add-on.** The patient participation should always be reported on the last portion of the month. **DO NOT prorate** the patient participation. (See *Attachment E*.)

**Patient Discharge in Current Month**

If you make any change(s) to the preprint *to reflect a discharge* from the nursing facility for the current month's TAD, the *Comments* section should also show the actual date of discharge (e.g., home 9-28-97, or expired 8-25-97).

When discharging a client from your facility, use the appropriate discharge code in box 6, change the date in box 7, and enter the total days (not counting the discharge day) in box 8. (See *Attachment C.*)

**Patient Discharge in Prior Month**

If a patient is listed on the preprint, yet is no longer in your nursing facility, *or* he/she was never in your nursing facility, ***DO NOT WIPE OUT THIS LINE***. Use the appropriate discharge code to show that the patient has been discharged on the first of the month - for a result of zero (0) days. *Enter the reason for discharge and the actual date of discharge in the Comments sections. (See Attachment F.)*

**PERIOD OF SERVICE (Box 7)** Show the month services are rendered (e.g., January = 01, February = 02, etc.); the year services are rendered (97, 98, etc.); the beginning date of service; and the ending date of service.

**TOTAL DAYS (Box 8)** Total days billed.

**PAYABLE BY PATIENT (Box 9)**

Box 9 is to be used *only* for the amount payable by the patient. ***DO NOT*** add any insurance payments into this amount. If an insurance payment has been received, see *Third-Party Liability*, Section III. (See *Attachments G and L.*)

**Patient Participation** - Any amounts of funds (e.g., SSA, pensions, veterans payments) that are treated as income during the eligibility determination. These funds must be contributed toward the patient's cost of care.

Patient participation may be increased at any time *without* an award letter. However, to *decrease* the patient participation by more than \$5.00, a current award letter is required and must be attached.

**PATIENT RATE (Box 10) Clients Receiving Exceptional Care: Class 25**

All exceptional care class changes must be accompanied by an Exceptional Care Letter from the DSHS Aging and Adult Services Administration. This letter must include the patient's name, your facility's name, the correct exceptional care rate, and the effective dates of the exceptional care rate. Please enter the exceptional care rate in box 10 on the TAD.

*(See Attachment H.)*

Whenever an exceptional care patient is discharged and then readmitted, a new request and an updated care plan must be submitted to the Aging and Adult Services Administration to reestablish the exceptional care rate.

Important: If you do not send an exceptional care letter with your TAD, you may be paid at the Skilled Nursing Facility rate.

**COMMENTS (Box 11)**

Enter any necessary comments here, such as "Insurance" and the name of the insurance company, new Medicare rate and effective date, etc.

**Add-Ons (New Admits, Readmits, or Services Previously Denied):***(See examples of add-ons on Attachments J & K)*

Add-ons are used when billing MAA for new admits, readmits, or previously denied services. List all add-ons in alphabetical order. If you are billing for more than one month for the same patient, list each month in order, starting with the earliest month.  
DO NOT list different months on separate pages.

**FILLING OUT ADD-ON PAGES**

- | <b><u>Box #:</u></b> | <b><u>Description/Instructions for Completion:</u></b>  |
|----------------------|---|
| 1.                   | <b><u>Initials:</u></b> Enter the client's first and middle initials as shown on the award letter.  |
| 2.                   | <b><u>Birthdate:</u></b> Month/Day/Year (MMDDYY).   |
| 3.                   | <b><u>Patient Name:</u></b> Enter the client's last name, first name, and middle initial.   |
| 4.                   | <b><u>T/B:</u></b> Tiebreaker as shown on the award letter.   |
| 5.                   | <b><u>Patient Class:</u></b> See <i>Patient Class Codes</i> on page 14.   |
| 6.                   | <b><u>Discharge Code:</u></b> See <i>Discharge Codes</i> on page 17. Enter <b>6</b> if the client is still a resident in your nursing facility.   |
| 7.                   | <b><u>Period of Service:</u></b><br><br><b>MM:</b> Enter the month during which services were rendered<br><b>YY:</b> Enter the year during which services were rendered<br><b>FROM DATE:</b> Enter either the admission date, the date of a patient class change, <i>or</i> the beginning date of the period for which you are billing, whichever is applicable<br><b>TO DATE:</b> Enter the discharge date, the last date before a patient class change, <i>or</i> the ending date of the period for which you are billing, whichever is applicable. |
| 8.                   | <b><u>Total Days:</u></b> Enter the total number of days for which you are billing. You will not be paid for the day of discharge ( <i>exception:</i> discharges 0 and 6, discussed on page 17).  |
| 9.                   | <b><u>Payable by Patient:</u></b> Enter the entire amount indicated on the award letter for the month. If the patient has more than one line for the same month (i.e., discharge and readmit), the patient pay is always reported on the <i>last portion of the month</i> for which you are billing.  |
| 10.                  | <b><u>Patient Rate:</u></b> Enter the patient rate for <i>class 25</i> only.  |
| 11.                  | <b><u>Comments:</u></b> Use this section for special notation (e.g., "Insurance" and name of insurance company or "Readmit").   |

## **ADMITS/AWARD LETTERS**

### **ADMITTING NEW CLIENTS**

When new MAA clients are admitted to your facility:

1. Submit a legible copy of the award letter (including all the pages) for all new admissions with the TAD.
2. The admit date must be within 30 days following the award letter's institutional care effective date.
3. The admit date may not be prior to the award letter institutional care effective date.

### **READMITS**

A new award letter is required for clients discharged and not readmitted within 30 days.

### **AWARD LETTERS MUST INCLUDE THE FOLLOWING INFORMATION:**

- Client name
- Facility name
- Effective date of placement (i.e., institutional care eligibility date)
- Patient participation
- The date the award letter was issued

### **IMPORTANT: MAA CANNOT ACCEPT ALTERED AWARD LETTERS!**

*If any of the above listed information is missing or altered, the award letter will not be accepted. Please contact your local Home and Community Services Office for a valid award letter.*

### **CHANGES TO SERVICES PREVIOUSLY BILLED**

If a claim has a date of service previously billed and has been denied, you may rebill on the TAD as an add-on. Rebill on the TAD for **DENIED services only**.

### **ADJUSTMENT REQUESTS**

If changes need to be made to claims for dates of service that have already been paid (e.g., because of a change in patient participation, split months, discharge in error), you *must* submit an adjustment request (Form 525-109). **DO NOT REBILL ON THE TAD.**

**This is a blank page.**



## INSTITUTIONAL AWARD

COMMUNITY SERVICES OFFICE (CSO)		TELEPHONE NUMBER
CASE NUMBER		DATE
PATIENT IDENTIFICATION CODE		SOCIAL SECURITY NUMBER
CLIENT NAME		
FACILITY NAME		
FACILITY STREET ADDRESS		
CITY	ZIP CODE	
TYPE OF ACTION		
<input type="checkbox"/> Application <input type="checkbox"/> Other (specify):		
<input type="checkbox"/> Eligibility review		
<input type="checkbox"/> Change in participation		
<input type="checkbox"/> Amends letter of: _____		

### 1. YOU WILL RECEIVE:

- ☐ Institutional and medical care. You are eligible for medical care beginning: \_\_\_\_\_
- ☐ Institutional care only. The attached Applicant Liability Letter, DSHS 14-196(X), explains why you do not get a medical ID card.

### 2. YOU ARE ELIGIBLE FOR THE FOLLOWING INSTITUTIONAL LEVEL OF CARE BEGINNING:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Nursing facility (20) _____   | <input type="checkbox"/> Exceptional care (25) _____       | <input type="checkbox"/> In-patient psychiatric _____ |
| <input type="checkbox"/> Institution for MR (23) _____ | <input type="checkbox"/> Nursing facility swing (26) _____ | <input type="checkbox"/> Hospice care _____           |
| <input type="checkbox"/> Class 5 Medicare (24) _____   | <input type="checkbox"/> Hospital care _____               |   |

### 3. YOUR INCOME/EXCESS RESOURCES ARE:

SOURCE/TYPE	RECEIVED BY/FOR	Month:	Month:	Month:
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
TOTAL INCOME/EXCESS RESOURCES:		\$	\$	\$

### 4. USE THIS AMOUNT OF YOUR INCOME FOR:

<input type="checkbox"/> Personal expenses (CPI) _____	Month:	Month:	Month:
<input type="checkbox"/> Spouse (income/shelter) allowance _____	\$	\$	\$
<input type="checkbox"/> Spouse (dependent) allowance _____	\$	\$	\$
<input type="checkbox"/> Health insurance premiums _____	\$	\$	\$
<input type="checkbox"/> Noncovered medical expense _____	\$	\$	\$
<input type="checkbox"/> Other (specify): _____	\$	\$	\$

### 5. YOU MUST PAY YOUR PROVIDER THE FOLLOWING:

- \_\_\_\_\_ for the month of \_\_\_\_\_
- \_\_\_\_\_ for the month of \_\_\_\_\_
- \_\_\_\_\_ for the month of \_\_\_\_\_ and each month thereafter.
- ☐ Medicare pays all or part of your care, read A.3. on the back of this letter.
- ☐ Nursing Facility Insurance pays all or part of your care, read A.4. on the back of this letter.
- ☐ Hospice, pay the amount listed above directly to the hospice agency.

### 6. IF YOU HAVE A SPOUSE AT HOME:

- ☐ Your spouse must provide the following information to this office within 10 days:
- ☐ You must transfer resources in the amount of \$ \_\_\_\_\_ to your community spouse before \_\_\_\_\_;
- ☐ Other (specify): \_\_\_\_\_

### 7. COMMENTS:

FINANCIAL SERVICES SPECIALIST'S SIGNATURE

IMPORTANT: READ ALL OF THE INFORMATION ON THE BACK OF THIS LETTER.

#### DISTRIBUTION:

- |                                   |  |   |
|-----------------------------------|--|---|
| <input type="checkbox"/> Client   | <input type="checkbox"/> Facility                | <input type="checkbox"/> Hospice Agency   |
| <input type="checkbox"/> CSO File | <input type="checkbox"/> Guardian/Representative | <input type="checkbox"/> Community Spouse |

## INFORMATION ABOUT THIS LETTER

### A. ACTION YOU MUST TAKE

1. **Resources:** You may keep \$2,000 in resources. If your resources are over \$2,000 on the first day of the month, you must report it to your CSO. You will have to use the excess as part of your cost of care. If the excess is too high you may be ineligible for that month.
2. **Changes:** You must tell us about changes in your or your spouse's circumstances. Report the changes in living arrangements, income, resources, shelter expense, marital status, etc., as soon as you know about them to your CSO.
3. **Medicare:** If Medicare pays for all of your care for a month, you keep the amount listed in Number 5 on the front of this letter, for that month. If they pay only part of your care, the bookkeeper at your facility will tell you the amount you are to pay. If the amount you are to pay is less than the amount listed in Number 5, you can keep the difference. We will add the difference to your resources the first of the next month unless you spend it before then.
4. **Nursing Home Insurance:** If insurance pays for your care, send the check along with a memo listing the information from the top of this award letter, e.g., your name, case number, medical identification number and facility name to: OFFICE OF FINANCIAL RECOVERY - MED, PO BOX 9501, OLYMPIA WA 98507-9501. The amount received by Financial Recovery - MED will reduce the amount DSHS pays for your care. We will refund any excess to you.

### B. MEDICAL IDENTIFICATION CARD

If Section 1, of this letter shows you are eligible for institutional and medical care, you will receive a medical ID card each month you are eligible. Use the identification (ID) card for medical care not covered by the facility.

### C. FAIR HEARING INFORMATION

1. If you disagree with our decision, you may ask for a fair hearing. To request a fair hearing, contact this office or write to: OFFICE OF APPEALS, DEPARTMENT OF SOCIAL AND HEALTH SERVICES, PO BOX 2465, OLYMPIA WA 98507. You must request your fair hearing within 90 days of the date you receive this letter.
2. At the hearing, you have the right to represent yourself or be represented by an attorney or by any other person you choose. You may be able to get free legal advice or representation by contacting an office of legal services.
3. If you want information regarding a department conference or continued benefits pending the hearing, contact your Community Services Office (CSO). You must make contact within ten days of the date you receive this letter or by the effective date of this letter.

KELSO CSO  
711 VINE ST  
KELSO WA 98626

Date: 08/22/1997  
Office Ph #: 577-2001  
LD PH #: 800-244-3170 Toll-Free

BRENDA N SULLIVAN  
FOR: SPECIFIC NURSING FACILITY  
123 - 45TH AVENUE  
ANYTOWN WA 98504

Client Id # : 123456789  
Worker: SHELLEY R.  
Worker Ph #: (360) 753-4209

\*\*\*\*\*

NOTICE OF APPROVAL FOR MEDICAL BENEFITS (LONG TERM CARE) - 00002  
You are eligible for institutional and medical benefits.

Your

SSI RELATED LONG TERM CARE  
medical benefits begin

08/01/97

Your institutional benefits begin

08/06/97.

You are eligible for the following institutional level of care:  
MEDICAID NURSING FACILITY

Each month you must pay part of your income and any excess resources towards the cost of your care. We determine the amount you must pay by subtracting expenses from your income and excess resources, such as expenses for your personal needs, the needs of your spouse or other family members at home, medical expenses not covered by medical benefits, and other expenses. The amount of your income and excess resources remaining after these expenses is the amount you must pay for your care.

Use part of you income each month for the following:

Personal Expense (CPI)	\$41.62
Spousal/Family Allowance	\$0.00
Housing/Maintenance Allowance	\$0.00
Non-covered Expenses	\$81.00
(See ***ADDITIONAL INFORMATION*** below if an amount appears in the Non-covered Expenses row.)	

Based on the information we now have, you must pay your care provider the amounts listed below toward the cost of your care. If your situation changes, the amount you are required to pay may change.

AUGUST \$543.38

Your ongoing participation is \$543.38 effective 08/01/97.

We have looked at eligibility for all Department of Social and Health Services (DSHS) medical programs. Coverage is denied for all programs not listed on this notice.

You may keep \$ 2000.00 in resources.

If your resources are over this amount on the first day of the month, you must report it to your Community Services Office (CSO). You will have to use the excess as part of your cost of care. If the excess is too high you may be ineligible for that month.

You must report any changes in your marital status, living arrangement, income and/or resources to your CSO in writing, as soon as they occur.

If you are married and part of your income is used for your spouse or a dependant, tell the CSO of any change in your spouse's income, shelter costs and/or dependent's income.

If medicare pays for all or part of your care, the bookkeeper at your facility will tell you the amount you are to pay. If the amount you are to pay is less than the amount listed above, you can keep the difference. We will add the difference to your resources the first of the next month unless you spend it before then.

If Nursing Home Insurance pays for your care, send the check along with a memo listing the information from the top of this letter; i.e., your name, client identification number, medical identification number and facility name to:

OFFICE OF FINANCIAL RECOVERY - MED  
PO BOX 9501  
OLYMPIA, WA 98507-9801

The amount received by Financial Recovery - MED will reduce the amount DSHS pays for your care. We will refund any excess to you.

## **CREATING A NURSING FACILITY-GENERATED TAD**

If you do not receive a TAD from DSHS, you may fill out and send in your own on the Nursing Home Statement Form (DSHS 525-010). The general instructions for correcting a TAD still apply.

In addition, you must enter the following information in the top left corner of the Nursing Home Statement Form (see *Attachment K*):

- Your facility's name.
- Your facility's mailing address underneath the name.
- Your MAA nursing facility provider number (beginning with "4").

The procedure for filling out boxes 1 through 11 is the same as for add-ons (see page 13).

Please be sure to sign, date, and enter your billing clerk's telephone number in the space provided in the bottom right of the form.

**NOTE:** MAA is only able to process one TAD for your facility per month. If you submit multiple TADs, partial TADs, or a department-generated AND a facility-created TAD, MAA will process and pay only the first TAD form it receives. *Please submit all TAD billings in one package, with applicable backup documents, by the monthly deadline.*

## STATEMENT

## WHAT TO



11

INITIALS	2 BIRTHDATE			3 PATIENT NAME LAST	FIRST	4 INIT.	PAT. CLASS	S C <sub>H</sub>	MM	YY	FROM DATE	TO DATE	TOTAL DAYS	PAYABLE BY PATIENT	PATIENT RATE	COMMENTS
	MM	DD	YY													
M-	06	02	10	Anela, Melvin		A	<del>20</del> 24	6	08	97	01	31	31	00 100		
E-	09	08	14	Sneed, Eleanor		A	<del>20</del> 25	6	08	97	01	31	31	00 100	29000	AASA letter attached

Melvin Aneia is on the preprint TAD as class 20 for August. He is being changed to class 24 for that entire month.

Elleanor Sneed is on the preprint TAD as class 20 for August. She is being changed to class 25 for that entire month. The change to class 25 requires an Exceptional Care Letter and the patient's exception care rate must be entered in Box 10

I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington, that no part of the same has been paid and I am authorized to sign for the paying, and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap, that the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

PROVIDER SIGNATURE

DATE \_\_\_\_\_

TELEPHONE NO. 1

STATE COPY

## NURSING HOME STATEMENT

MAIL TO: OFFICE OF PROVIDER SERVICES  
P. O. BOX 9250  
OLYMPIA, WA 98507-9250

**EXCERPTS  
FROM THE  
JOURNAL OF  
NUTRITION**

## STATEMENT

PATIENT IDENTIFICATION CODE (PIC)																			
2		3		4		5		6		7		8		9		10		11	
BIRTH DATE		PATIENT NAME		INIT.		PAT. CLASS		PERIOD OF SERVICE		TOTAL DAYS		PAYABLE BY PATIENT		PATIENT RATE		COMMENTS			
MM	DD	YY	LAST	FIRST	1/3	MM	YY	MM	YY	FROM DATE	TO DATE	MM	YY	MM	YY	MM	YY	MM	YY
E-	03	03	12	Anex, Evelyn	A	24	6	08	97	01	06	06	846	38					

**PATIENT CHANGE FROM CLASS 24 TO CLASS 20**

Evelyn Anex, on the preprint as a *class 24* (Dual Medicare/Medicaid), has been changed to a *class 20* (skilled nursing) during the month. Since this class change is not for the entire month, show clearly how the billing should be split. Do this by writing the dates of service for the old class below the preprint on the same line.

Box 5: Below the previous class (24), the new class (20) is written in.

Box 6: Since a class change is not a discharge, code 6 (still a patient) is not crossed out.

Box 7: The preprinted TO Date is crossed out and the last day (August 6) in the old class is written in.

Box 7: The first day (August 7) of the new class is written below the old in the FROM Date.

Box 7: The last day (August 31) of the new class is written below the old TO Date.

Box 8: The total days (25 days) of the new class is written below the old Total Days.

Box 8: The preprinted Total Days is crossed out, and above it the total days (6 days) of the old class is written in.

It is not necessary to overlap the TO Date for the old class with the FROM Date for the new class in order for you to be paid for all days of the old class.

- 29 -

hereby certify under penalty of perjury, that the information is true and correct to the best of my knowledge and belief, and that the foregoing information is true and correct to the best of my knowledge and belief.

and necessary to the health of this patient and were personally rendered by me or  
by accurate and complete.

PROVIDER SIGNATURE

STATE COPY

TELEPHONE NO. ( )

DATE \_\_\_\_\_

# ATTACHMENT C DISCHARGE TO HOSPITAL

MAIL TO: OFFICE OF PROVIDER SERVICES

P.O. BOX 9250

O.W.M.P.A., WA, 98507-9250



PATIENT IDENTIFICATION CODE (PIC)										PATIENT RATE		COMMENTS						
INITIALS	BIRTHDATE		PATIENT NAME		4	5	PERIOD OF SERVICE			8	9		10	11				
	MM	DD	YY	LAST	FIRST	INIT.	T/B	PAT CLASS	DD	MM	YY	FROM DATE	TO DATE	TOTAL DAYS	PAYABLE BY PATIENT	PATIENT RATE		
JA	06	07	21	Brown, Jane A.				A	20	1	08	97	01	30	30	00		To Hospital 8/21/97
<div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <p><b>DISCHARGED TO HOSPITAL</b></p> <p>Enter the discharge code in box 6, the date of discharge in box 7, and the new total in box 8.</p> <p>Note regarding Box 8: The nursing facility does not get paid for the date of discharge.</p> </div>																		

I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payee; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap, that the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

525-010 (10/82)

STATE COPY

PROVIDER SIGNATURE

DATE

TELEPHONE NO. ( )

## STATEMENT

MAIL TO: OFFICE OF PROVIDER SERVICES  
P.O. BOX 9250  
OLYMPIA, WA. 98507-9250



PATIENT IDENTIFICATION CODE (PIC)										PATIENT RATE		COMMENTS									
2 BIRTHDATE			3 PATIENT NAME		4		5 PAT. CLASS		6 DATES		7 PERIOD OF SERVICE		8 TOTAL DAYS		9 PAYABLE BY PATIENT		10		11		
INITIALS		MM	DD	YY	LAST		FIRST	INIT.	T/B												
M-060210					Anela, Melvin				A	20	00897	10	10	1	31592					Admit and expired 8-10-95	

**ADMIT AND DISCHARGE ON THE SAME DAY**

8. Report patient payment, if any, in box 9.

NOTE: This does not include readmits or social leave.

to hereby certify under penalty of perjury, that the material furnished and service rendered is a earned charge against the State of Washington; the claim is just and due; that no part of the same has been paid me. I am authorized to sign for the payor, and that all goods furnished and/or services rendered have been provided without discrimination on two grounds of race, creed, color, national origin or the presence of any sensory or mental handicap, that the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

525-D10 (10/82)

STATE COPY

TELEPHONE NO. ( )

TELEPHONE NO. ( )

## ATTACHMENT E:

## DISCHARGE AND READMIT

MAIL TO: OFFICE OF PROVIDER SERVICES

P.O. BOX 9250

Olympia, WA 98507-9250



2		3		4		5		6		7		8		9		10		11	
INITIALS		BIRTHDATE		PATIENT NAME		PAT CLASS		PERIOD OF SERVICE		TOTAL DAYS		PAYABLE BY PATIENT		PATIENT DATE		COMMENTS			
MM	DD	YY	FIRST	LAST	INIT.	T/B	PAT CLASS	MM	YY	MM	YY	FROM DATE	TO DATE	TOTAL DAYS	PAYABLE BY PATIENT	PATIENT DATE	COMMENTS		
M-	06	02	10	Anela, Melvin	A		20	08	97	05	05	05	05	05	00:00				
L-	09	22	14	Bellfiar, Lucille	C		20	08	97	01	01	01	01	01	352:30		Readmit 8-10-97 See Add-On Pg		

## DISCHARGE AND READMIT

The preprint method is used for Melvin Anela.

The add-on method is used to indicate Lucille Bellfiar was readmitted.

I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payment; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap, that the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

525-010 (10/82)

STATE COPY

PROVIDER SIGNATURE

DATE

TELEPHONE NO. ( )

## STATEMENT

OLYMPIA WA 98507-9250



## MANUFACTURERS HAVE ATTNMENT OF AN AFFAIR SERIES

ATTACHMENT F: PATIENT  
DISCHARGE IN PRIOR MONTH

PATIENT IDENTIFICATION CODE (PIC)											COMMENTS				
INITIALS	2 BIRTHDATE		3 PATIENT NAME LAST	4 FIRST	INITIAL	5 PAT. CLASS	6 DO	7 PERIOD OF SERVICE				8 TOTAL DAYS	9 PAYABLE BY PATIENT	10 PATIENT RATE	11
	MM	DD						YY	MM	YY					
M-	06	02	10	Anela, Melvin	A	20	8	08	97	01	01	0	00	00	went home 6.28.97
E-	03	13	12	Anex, Evelyn	A	20	8	08	97	01	01	0	846	38	Expired 6.25.97

**PATIENT DISCHARGE IN PRIOR MONTH**

Melvin Anela was discharged to his home on 7/28/97. The facility should have shown him as discharged on the June TAD, but instead is correcting this error here. Instead of obliterating the line, a 5 is entered in box 6, the TO Date in box 7 is changed to 01, the Total Days in box 8 is changed to 0, and the date and type of discharge are written in the Comments section.

The same is done for Evelyn Anex, except that the discharge code used is 4, for expired.

I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid; and I am authorized to sign for the payee; and that all goods furnished and/or services rendered have been procured without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or physical handicap. That the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

PROVIDER SIGNATURE

DATE \_\_\_\_\_

OLYMPIA, WA. 98507-9250



## PATIENT IDENTIFICATION CODE (PIC)

PATIENT IDENTIFICATION CODE (PIC)																
INITIALS	2 BIRTHDATE			3 PATIENT NAME			4			5 PAT CLASS	6 DISCH	7 PERIOD OF SERVICE				8 TOTAL DAYS
	MM	DD	YY	LAST	FIRST	INIT.	T/B	MM	YY			FROM DATE	TO DATE			
M-	06	02	10	Anela, Melvin			A	20	6	08	97	01	31	31	00-00-31592	
E-	03	03	12	Anex, Evelyn			A	20	6	08	97	01	31	31	046-00-72536	Award letter Attached

I hereby certify under penalty of perjury, that the material furnished and services rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payee; and that all amounts furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap. That the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

STATE COPY

PROVIDER SIGNATURE

TELEPHONE NO. ( )

## STATEMENT

**ATTACHMENT H:  
EXCEPTIONAL CARE RATE**

MAIL TO: OFFICE OF PROVIDER SERVICES

P. O. BOX 9250

OLYMPIA, WA 98507-9250

[illegible]

I hereby certify, under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payment; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap. That the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

525-010 (10/82)

PROVIDER SIGNATURE

DATE \_\_\_\_\_

STATE COPY

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## NURSING HOME STATEMENT

MAIL TO: OFFICE OF PROVIDER SERVICES

P.O. BOX 9250

OLYMPIA, WA. 98507-9250

ATTACHMENT I

FULL MEDICARE PATIENTS



PATIENT IDENTIFICATION CODE (NIC)				PERIOD OF SERVICE				TOTAL DAYS	PAYABLE BY PATIENT	PATIENT RATE	COMMENTS				
INITIALS	2	BIRTHDATE	3	PATIENT NAME	4	INIT.	5					6	7	8	9
	MM	DD	YY	LAST	FIRST		PAI CLASS	DD	MM	YY	FROM DATE	TO DATE			
SS	01	06	28	Smith, Samuel	J.	A	20	1	08	97	01	05	04	0.00	Admit Full
SS	01	06	28	Smith, Samuel	J.	A	29	6	08	97	09	28	20	0.00	Medicare 8-9-97
SS	01	06	28	Smith, Samuel	J.	A	24	6	08	97	29	31	3	250000	Medicare Coin Surgery 8-29-97
JM	05	25	31	Johnson, Janie	M.	B	29	6	08	97	06	25	20	0.00	Admit Full
JM	05	25	31	Johnson, Janie	M.	B	20	6	08	97	26	31	6	48100	Medicare

## FULL MEDICARE PATIENTS

Samuel Smith was discharged to the hospital on 8-05-97. He returned to the nursing facility on 8-9-97 with a payable in full status with Medicare from 8-9-97 to 8-28-97. His class 29 status was changed to class 24 (Dual Medicare/Medicaid) on 8-29-97.

Janie Johnson was admitted on 8-06-97. Her care was paid for in full by Medicare, class 29, from 8-06-97 to 8-25-97. She became a class 20 client (SNF) on 8-26-97.

I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington, the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payee; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap; that the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction and that the foregoing information is true, accurate and complete.

525-010 (10/82)

PROVIDER SIGNATURE

DATE

STATE COPY

TELEPHONE NO. ( )

# NURSING HOME STATEMENT

MAIL TO: OFFICE OF PROVIDER SERVICES  
P.O. BOX 9250  
OLYMPIA, WA 98507-9250



## ATTACHMENT J: ADD-ON EXAMPLE

1 INITIALS	2 BIRTH DATE		3 PATIENT NAME		4 PAT. CLASS		5 PERIOD OF SERVICE			6 TOTAL DAYS		7 PAYABLE BY PATIENT		8 PATIENT RATE		9 COMMENTS	
	MM	DD	YY	FIRST	LAST	INIT.	MM	YY	HH	FROM DATE	TO DATE	MM	YY	HH	MM	YY	HH
LA 01	05	05	05	Abbott, Lawrence	A.	A	A	20	1	0897	0105	04	000			To Hospital	
LA 01	05	05	05	Abbott, Lawrence	A.	A	A	24	6	0897	0728	22	000			8/5/97 off medicare insurance	
LA 01	05	05	05	Abbott, Lawrence	A.	A	A	20	6	0897	29	31	342	150		To Medicaid	
L- 09	22	14		Bellfair, Lucille			C	20	6	0897	10	31	22	352	338	Readmit	
LB 05	02	10		Carson, Lawrence	B.	C	20	6	0897	01	31	25	000			In S. Payment	
LB 05	02	10		Carson, Lawrence	B.	C	20	2	0897	01	21	20	25	000		Transferred	
LB 05	02	10		Carson, Lawrence	B.	C	20	6	0897	01	31	31	150	00		6/21/97 Dropped from TAD	

### EXAMPLE OF ADD-ONS

This is an Add-On page for a TAD for August 1997 services.

Lawrence Abbott was admitted to the facility on August 1, 1997. He does not appear on the preprint pages because he was not billed for on the July 1997 TAD. He was discharged to the hospital on August 5, readmitted to the nursing facility on August 7, and changed classes from 24 to 20 on August 29.

Lucille Bellfair was shown as discharged on the August TAD and was readmitted to the nursing facility on August 10.

The nursing facility has never been paid for Lawrence Carson's May and June dates of service. Now they are billing for admitting him on May 1 with a comment that insurance paid \$1,051.00. He was transferred to another facility on June 21.

Lawrence Carson, who appeared on the July TAD preprint, is not on the August TAD preprint. She is added back on with the comment "dropped from TAD."

I hereby certify a claim is just and services rendered under my personal direction, and that the foregoing information is true, accurate and complete.  
525-0110 (10/82)

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STATE COPY

TELEPHONE NO. ( )

DATE

## NURSING HOME STATEMENT

OLYMPIA, WA 98507-9250



PATIENT IDENTIFICATION CODE (PIC)

INITIALS	2 BIRTH DATE			3 PATIENT NAME		4	PAT. CLASS	L	MM	YY	FROM DATE	TO DATE	TOTAL DAYS	PAYABLE BY PATIENT	PATIENT RATE	COMMENTS
	AAA	DD	YY	LAST	FIRST											
AB	03	03	63	Cadwallader, Able	B.	A	20	6	08	97	12	30	19	000		Entered facility 8-12-97
EF	07	03	45	Dupruiis, Edgar	F.	A	24	6	07	97	31	31	1	000		Admit Medicare
EF	07	03	45	Dupruiis, Edgar	F.	A	24	6	08	97	01	19	19	000		Coinurance 07-31-97
EF	07	03	45	Dupruiis, Edgar	F.	A	20	6	08	97	20	27	7	000		Discharge Hospital 8-27-97
<div>ATTACHMENT K: NURSING FACILITY-CREATED TAD</div>																

ATTACHMENT K: NURSING  
FACILITY-CREATED TAD

I hereby certify under penalty of perjury, that the narrative furnished and service rendered is a correct charge against the State of Washington, the claim is just and due, that no part of the same has been paid and I am authorized to sign for the payee, and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap, that the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

525-0110-100/B/2)

PROVIDER SIGNATURE

DATE \_\_\_\_\_

STATE COPY

TELEPHONE NO. (

## STATISTICAL STATEMENT

## PATIENT IDENTIFICATION CODE (PIC)

PATIENT IDENTIFICATION CODE (PIC)											11	10	9	8	7 PERIOD OF SERVICE				6 D L S CH		5 PAT. CLASS	4	3	2 BIRTH DATE			1
INITIALS	MM	DD	YY	PATIENT NAME LAST	FIRST	MID.	T/B	PAT. CLASS	D	L	S	CH	MM	YY	FROM DATE	TO DATE	TOTAL DAYS	PAYABLE BY PATIENT	PATIENT RATE	COMMENTS							
JA	06	07	21	Brown, Jane A.			A	20	6	08	97	01	31	31	560.00						Blue Cross/Wf Ins Paid \$1,360.00						

**THIRD-PARTY LIABILITY**

Jane Brown's insurance paid \$1,360.00 to her designee for services rendered in August. The insurance carrier was identified.

Submit Adjustment Form 525-109 to credit the insurance payment.

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I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payment, and that all goods furnished and/or services rendered have been provided without duplication on the grounds of race, creed, color, national origin or the presence of any sensory or mental handicap; that the services listed were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, and that the foregoing information is true, accurate and complete.

RECEIVED SIGNATURE

TELEPHONE NO. 1

STATE COPY

DATE \_\_\_\_\_

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